SUPERIOR VISION

Enrollment/Change Form

Employer: WAUKESHA COUNTY **Group Number:** _____

Date of Hire: _____ **Effective Date:** _____

Employee Information

Employee Name: _____
First M.I. Last

Employee Soc. Sec. # _____-_____-_____ Sex: ☐ M ☐ F

Employee Birthdate: _____/_____/_____ Home Phone: (_____)_____

Home Address: _____

City: _____ State: _____ Zip: _____

COVERAGE: ☐ SINGLE ☐ E+1 ☐ FAMILY

PLAN: ☐ FULL SERVICE (exam & materials) ☐ WAIVE

Covered Dependents

Name	Add/Term	Birthdate	Relationship	Soc. Sec. #
		/ /		- -
		/ /		- -
		/ /		- -
		/ /		- -
		/ /		- -
		/ /		- -

EMPLOYEE SIGNATURE: _____ DATE: _____

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